Instructions for completing the MAP-23

Medicaid providers participating in the Home and Community Based (HCB) Waiver program use the MAP-23. The Home and Community Based Waiver Services, Selection of Provider Form (MAP-23) is designed to be an instrument that is utilized:

1. To allow the HCB Waiver member the freedom to select whom will provide reassessment and/or case management services;
2. To document which provider is chosen to provide the reassessment service;
3. To document which provider is chosen to provide case management services;
4. To allow, at any time, the HCB Waiver member the freedom to make changes to whom will provide the reassessment and/or case management services; and
5. By the PRO (QIO) to maintain a record of selected (current) providers.

General Information Regarding the MAP-23

For the Home and Community Based Waiver Services, Selection of Provider Form (MAP-23) to be useful and meaningful to the process of service provision to Medicaid HCB Waiver members, the following points must be addressed:

1. The current case manager must explain to the HCB Waiver member that he or she has the freedom to choose who will provide the reassessment service, the case management services and the effective date for each;
2. The HCB Waiver member shall be provided with a list of providers to choose from and be given the opportunity to make a decision;
3. Once a member selects a provider, the current case manager must contact that provider to determine if that agency is able to begin providing the appropriate service. If the selected provider is unable to provide the service, the current case manager is to inform the member and allow the member to select another provider;
4. The current case manager must complete the MAP-23 form and submit a copy of the form to the PRO and to the provider or providers selected to begin providing reassessment and case management services. A copy of the MAP-23 must be submitted to the PRO each time the member makes a change. The original must be filed in the medical record of the HCB Waiver member;
5. The case manager must attach a copy of the current MAP-23 to the MAP 109-HCBW any time a new MAP 109-HCBW form is completed; and
6. The HCB Waiver member needs to understand that whomever is chosen to provide the reassessment and/or case management services, the member will receive those services which are authorized by Medicaid and included on the plan of care.

The Document (MAP-23):

Section I:

- **Name**: Enter the last, first and Middle name of the HCB Waiver member.

- **Date of Birth**: Enter the two-digit calendar month (for example, **04** for April), the two-digit calendar day (for example, **17**), and the four-digit calendar year (for example, **1972**) of the member's birth.
- **County of Residence**: Enter the county where the member lives.
- **Medicaid Identification Number (MAID)**: Enter the ten- (10) digit number found on the front of the medical card. If the medical card has not been issued, enter the individual's nine- (9) digit Social Security Number.
- **Street**: Enter the member's actual street address. In addition to the actual street address, you may include a PO Box, if appropriate.
- **City**: Enter the name of the city where the member lives.
- **State**: Enter the state where the member lives, especially if outside Kentucky.
- **Zip Code**: Enter the member's zip code.
- **Member's Telephone #**: Enter the area code and telephone number for the member.
- **Alternate Telephone #**: Enter the area code and telephone number that the member uses to receive phone calls, should the member not have a phone in the home.
- **Representative's Name & Telephone #**: Enter the member's designated/authorized representative and the representative's telephone number including area code.

Section II:

- **Current Reassessment Provider's Name & Telephone #**: Enter the name and telephone number including area code of the individual who completed the current MAP-351A and obtained the verbal level of care from the PRO.
- **Agency Name**: Enter the name of the Home Health Agency or Adult Day Health Care Center that employs the individual that completed the current reassessment.
- **Provider #**: Enter the provider number of the agency providing the reassessment service (beginning with a 42 or a 43 only).
- **Member's selection of provider statement**: Enter the name of the provider that has been selected to begin providing the reassessment service and the effective date. Enter this information even if there has not been any changes from the current provider.
- **Selected Agency's Name**: Enter the name of the Home Health Agency or Adult Day Health Care Center that the member chose to begin providing the reassessment service.
- **Provider #**: Enter the provider number of the agency selected to provide the reassessment service (beginning with a 42 or a 43 only).
- **Agency's address**: Enter the complete address of the agency selected to provide the reassessment service.
- **Telephone #**: Enter the area code and telephone number of the agency selected to provide the reassessment service.

Section III:

- **Current Case Manager's Name & Telephone #**: Enter the name and telephone number including area code of the individual (case manager) who completed the current MAP 109-HCBW and submitted the packet to the PRO. This individual should be the person completing the MAP-23 form.
- **Agency Name**: Enter the name of the Home Health Agency or Adult Day Health Care Center that employs the current case manager.
- **Provider #**: Enter the provider number of the agency providing the case management services (beginning with a 42 or a 43 only).
- **Member's selection of provider statement**: Enter the name of the provider that has been selected to begin providing case management services and the effective date. Enter this information even if there has not been any changes from the current provider.
- **Selected Agency's Name**: Enter the name of the Home Health Agency or Adult Day Health Care Center that the member chose to begin providing the case management services.
- **Provider #**: Enter the provider number of the agency selected to provide the case management services (beginning with a 42 or a 43 only).
- **Agency's address**: Enter the complete address of the agency selected to provide the case management services.
- **Telephone #**: Enter the area code and telephone number of the agency selected to provide the case management services.

Section IV:

Member's or Representative's Signature: Member or Member's legal representative must sign.
Date: Member or Member's legal representative must date.
Case Manager's Signature: Current case manager must sign.
Date: Current case manager must date.